



Duke Gastroenterology of Raleigh

New Patient Form

Date: _____ Name: _____ Date of Birth: _____ Telephone Number: _____

Address: _____ Email: _____

Referring physician: _____ Primary care physician: _____

What is the reason for your visit? How did you hear about our practice? _____

My physician recommended that I have a colonoscopy or EGD Other: _____

I have had a change in bowel habits, eating habits, and/or weight loss Amount of Weight Loss: _____ pounds

I am experiencing symptoms of acid reflux, difficulty swallowing or chronic cough

My physician referred me because my blood tests were abnormal or I had abnormal imaging studies (CT Scan, MRI, other)

Have you had a colonoscopy? Yes No If yes, when and where _____

Have you had an upper endoscopy? Yes No If yes, when and where _____

Are you experiencing any pain? YES NO If Yes where is the pain located: _____

Rate the pain on a scale from 1 – 10 (the worse pain): _____ Does anything relieve the pain: _____

When do you experience the pain: _____ Describe the pain: _____

Past Medical History: Which of the following conditions are you currently being treated or have been treated for in the past:

Colon Cancer Hepatitis A B C Heart Disease/Arrhythmia/Angina Asthma

Colon Polyps Liver Problems Heart Attack Emphysema/COPD

Irritable Bowel Syndrome Bleeding Disorders Stroke Chronic Cough

Crohn's Disease Anemia Kidney Disease Arthritis

Ulcerative Colitis High Blood Pressure Diabetes Cancer Type: _____

Stomach Ulcers Heart Disease Seizures Other: _____

Other: _____

Please list your hospitalizations and surgeries with approximate year:

Have you ever had a reaction to anesthetic? Yes No If yes, please describe: _____

Are you allergic to Latex? Yes No Do you have any drug allergies? Yes No

If YES, please list allergies: _____

Social and Preventive History:

Employment/Occupation _____ Single Married Divorced Life Partner/Significant Other Widow

Do you currently smoke/chew tobacco? Yes No Year Started _____ Are you still smoking? Yes No

If No, what year did you quit smoking: _____

How many alcohol drinks do you have per: _____ DAY/WEEK (circle) Other drug use? Yes No

Family Medical History

Please check and list the family member with the diagnosis: Mother, Father, Sister/Brother, Aunt/Uncle and Grandparents

- Colon Cancer _____ Crohn's Disease _____ Hypertension _____
- Colon Polyps _____ Ulcerative Colitis _____ Heart Disease (CAD) _____
- Cirrhosis of the Liver _____ Celiac Sprue _____ High Cholesterol _____
- IBS _____ Stomach Cancer _____ Stroke _____
- Peptic Ulcer Disease _____ Other Liver Disease _____ Alcoholism or other substance abuse _____
- Other _____ Diabetes _____

Review of Systems – Please check the symptoms you have been experiencing recently:

- General:** weight loss fatigue weakness fever chills night sweats
- HEENT:** vision changes hearing loss ringing in the ears nose bleeds
- Neck:** pain/difficulty swallowing sore throat lumps/masses in neck hoarseness
- Respiratory:** shortness of breath wheezing dry cough productive cough coughing up blood
- Cardiac:** palpitations chest pain short of breath with exercise swelling in legs short of breath when lying down
- GI:** nausea vomiting difficulty swallowing indigestion blood in stools
 constipation diarrhea change in bowel habits weight loss change in the color of stools
- GU:** difficulty urinating pain on urination prostate problems urinating multiple times at night blood in urine
- Vascular:** pain in calves when walking blood clots in legs
- Musculoskeletal:** pain/stiffness in bones or joints arthritis gout muscle weakness
- Neurologic:** numbness/weakness tingling tremors seizures blackouts headache
- Hematologic:** easy bruising/bleeding
- Endocrine:** heat/cold intolerance excessive thirst
- Psychiatric:** depression anxiety thoughts of suicide
- Skin:** skin hair or nail changes rashes sores jaundice



GUIDE FOR ALTERNATIVE MEANS OF COMMUNICATION

<p>Patient Name: _____</p> <p>Medical Record Number: _____</p> <p>Date of Birth: _____</p> <p>Specific Clinic Patient is seen at: _____</p>

The Health Insurance Portability & Accountability Act (HIPAA) requires the Private Diagnostic Clinic, PLLC (“PDC”) to have reasonable safeguards in place to protect our patients’ health information. In addition, HIPAA requires the PDC to reasonably limit incidental uses or disclosures of our patients’ protected health information (medical records), and agree to reasonable requests by our patients to communicate with them by alternative means or at alternative locations.

While we strive to provide our patients with prompt results of clinical and lab tests, the PDC’s providers are often asked to disclose the results to spouses, children, significant others, and other medical offices. In addition, some of the PDC’s patients prefer to receive messages left on home answering machines or work voice mails. Absent an agreement by a specific PDC clinic or clinical site to the contrary (which shall cover only that particular clinic or clinical site), the PDC reserves the right to use its professional judgment to determine what reasonable actions and safeguards it should take when communicating with its patients and individuals involved in our patients’ care. However, to help guide the PDC’s judgment, please complete the relevant portions below to help your PDC providers understand what alternative means of communication and disclosures to individuals involved in your care you would prefer so that the PDC providers may use this information to determine reasonable ways to inform you of your test results and other pertinent clinical information.

- Spouse Name/Number: _____
- Significant Other Name/Number: _____
- Child/Children Name/Number: _____
- Name/Number: _____
- Work Voice Mail Number: _____
- Answering Machine Number: _____
- Dr. Office Name/Number: _____
- _____
- Other _____

This form shall be used as a guide by the PDC providers, and it is not to be an agreement by the PDC to accept any restrictions or protections of the patient’s protected health information requested by the patient or the patient’s personal representative. In addition, this form is not a conclusive determination by the PDC that your requests for communications by alternative means or at alternative locations are reasonable. Further, this form shall be used only by the particular clinic or clinical site listed herein.